



American Limb & Orthopedic Co. of Valparaiso

201 E Morthland Drive Suite 2
Valparaiso, Indiana 46383
Phone: (219) 531-7479 Fax: (219) 531-0465
www.americanlimbvalparaiso.com

RELEASE/CONSENT FORM

PLEASE READ CAREFULLY AND INITIAL EACH ONE AND SIGN BELOW:

- _____ 1. The patient requests that payment of authorized insurance benefits be made, on the patient's behalf, to the American Limb & Orthopedic Company of Valparaiso for the orthotic or prosthetic services rendered. The patient understands that their signature (below) authorizes payment by the insurance carrier to be made directly to the American Limb & Orthopedic Company of Valparaiso.

- _____ 2. The patient authorizes any holder of medical information, regarding the patient that is needed for clinical purposes or for the determination of benefits, or benefits payable, for related services are released to the American Limb & Orthopedic Company of Valparaiso. The patient understands that their signature (below) authorizes the release of medical information.

- _____ 3. The patient agrees to assume financial responsibility for any claim not covered by the insurance policy or portion of claim thereof such as a non covered item, deductible, or co-pay due to the American Limb & Orthopedic Company of Valparaiso for services rendered. If the insurance company denies coverage for a product, the patient will assume financial responsibility for this payment. The patient acknowledges the responsibility for any payment not received from the insurance carrier within sixty (60) days from the date of service. Returned checks and balances older than 60 days may be subject to additional collection charges.

- _____ 4. (I) (We) the undersigned, as guarantor and agent of the abovementioned person or entity do hereby agree to pay all incurred charges mentioned above within 60 day of the time services were rendered (Date of Service). I further agree upon default to pay 1 ½ % per month (18% per annum) on any unpaid balances along with all costs of collection including reasonable attorney fees. I further agree that any dispute with regard to payment of this debt shall be subject to the laws of the State of Indiana and by my signature am submitting myself to the jurisdiction of the courts of Indiana. We accept major credit cards, cash, check, and money orders. Full payment is due on the date of service. For custom made items, we require a down payment of half the amount that is due before work will begin on any item.

- _____ 5. It is the responsibility of the patient to notify American Limb & Orthopedic Company of Valparaiso of any changes in insurance coverage, employment, functional status, or personal information such as address and telephone contact information.



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RELEASE/CONSENT FORM (page 2)

PLEASE READ CAREFULLY AND INITIAL EACH ONE AND SIGN BELOW:

_____ 6. Thank you for choosing American Limb & Orthopedic Company of Valparaiso for your orthotic and prosthetic needs. When you schedule an appointment with us, we reserve this time slot for you to be seen. Should you need to cancel or reschedule this appointment, please call our office at (219) 531-7479 as soon as possible. We will accommodate your needs to the best of our ability. Due to the amount of patients and our high standard of care, we ask that you please notify us if you will be more than 15 minutes late, as we may have to reschedule your appointment. Please notify us 24 hours in advance if you have any cancellations or reschedules. Failure to do so can result in a \$35.00 charge.

_____ 7. I certify that I have received a copy of American Limb & Orthopedic Company of Valparaiso's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of American Limb & Orthopedic Company of Valparaiso's health care operations. The Notice of Privacy Practices also describes my rights and American Limb & Orthopedic Company of Valparaiso's duties with respect to my protected health information. The Notice of Privacy Practices is posted in (reception area file cabinet) and on (www.AmericanLimbValparaiso.com). American Limb & Orthopedic Company of Valparaiso's reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing American Limb & Orthopedic Company of Valparaiso's website.

_____ 8. It is our policy per medical guidelines to keep a picture of your prosthetic/orthotic device on file. This will be kept in your file only to be used for verification of delivery in the event of an audit by Medicare or your insurance company. Your authorization is requested at this time.

(Print) PATIENTS NAME: _____ DATE: _____

X

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR GUARANTOR